

Disparities and HIT

Maryland Health Disparities Conference

Workforce and Cultural Diversity Public Health Forum

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Making an important distinction between HIT and HIE

- Health Information Technology (HIT)
 - The use of electronic information tools such as electronic charts, electronic prescribing, electronic ordering, clinical messaging, decision support, comparative analysis, etc. to improve quality and effectiveness of care.
 - HIT is essential, but not enough unless electronic systems are connected together, exchanging information.
- Health Information Exchange (HIE)
 - Two or more organizations that exchange data within and across naturally occurring medical referral regions enabling physicians to have access to the right information at the right time to improve the care of their patient.
 - HIE takes HIT to the next level of care.

Ways in which HIT and HIE can support and advance the elimination of minority health disparities:

- Support front-line physicians with easy electronic access to routine patient records, essential hospitalize patient records, lab results, and radiology reports through a community-wide clinical messaging system to improve patient treatment at the point of care.
- Establish a HD-HIE among safety net providers enabling them to exchange clinical data for common patients.
- Pilot a physician/public health electronic disease management system focused on priority diseases such as diabetes that demonstrate the use of electronic tools to eliminate duplication of lab testing, to reduce inefficiencies and to manage, assess and measure quality of care.
- Build a business and healthcare quality improvement case for HIT and HIE that demonstrates the cost/benefit of addressing disparities through HIT.
- Help build consensus to share data to increase awareness and access for women and minorities clinical trials for high priority chronic diseases (e.g. diabetes) by expanding front line physician access to electronic medical records and Health Information Exchanges.

Ways in which state health department can implement a HIT/HIE-Health Disparities Initiative:

1. Public health participates in a easy to use, low-cost community-wide clinical messaging system (HIE) along with healthcare providers to exchange clinical information enabling:
 - Providers to easily send reportable conditions to public health,
 - Public health to send electronic alerts and reminders to providers.
 - HIE to collect and feed de-identified data to public health and researchers to do analysis on disparities issues.
2. Participation by disparities and public health representatives on all community and state-wide HIE discussions.
3. The establishing of a Disparities and HIE committee to develop and implement strategies to bridge the barriers between entities focused on Disparities vs. HIE and work to establish joint strategies. Lay ground work for Health Disparity/HIE state wide taskforce (2008)

No Cost Scenario: Ensure there are disparities and public health representatives on all community and state-wide HIE discussions to help establish priorities.

1. The good news is that there is a roadmap of best practices for Maryland and public health. In only a few years, the number HIEs around the country have increased from under 25 to over 200, including Delaware, Maryland closest neighbor.
2. Most HIEs are NFP multi-stakeholder entities that include all or some of the following stakeholders on the governing board – public health, hospital systems, physicians, other providers, consumers, health plans, researchers, and employers.
3. Public Health is welcomed partner in these collaborations because 1) public health serves as a neutral party in collaborations between stakeholders; 2) public health provides services to the high cost segment of the population; and 3) is a key secondary user and disseminator of the information that flows through the community HIE.
4. Public Health activities that other community or state HIEs have adopted involving public health include but not limited to:
 - Electronic immunization registries available to physician EMRs.
 - Collection of Race and Ethnic data from any healthcare access point
 - Emergency Room physician access to patient data for 24 hours from multiple hospitals.
 - Chronic disease management by county health clinics and community health centers with access to community data.
 - State-wide public health alerts and reminders to physicians.
 - Electronic transfer and sharing of reportable conditions directly from the physician EMR to public health
 - Newborn screening reporting
 - Public health participation in a community clinical messaging system.
 - Access to test results for lead poisoning via community repository.
 - Electronic alerts to increase number of adults receiving age and sex appropriate preventive screenings
5. Activities above can, to varying degrees, be funded by the HIE.
 - Currently, MHCC is hosting discussions to establish (pilot) HIEs in Maryland.
 - The Maryland/DC HIE Collaborative (Dr Plavner) and other MHCC opportunities would establish HIEs around naturally occurring medical referral regions and/or among safety net providers.

- Maryland/public has a unique opportunity to also expand the access and availability of the “first” health disparities disease registries such as sickle cell, high risk pregnancies, and chronic diseases (diabetes, CHF, ESRD).

Low Cost Scenario: Participate in the initial services of the HIE as a provider of data and a user of data. Many successful HIEs around the country started with basic community-wide services that organized and focused the provider community. Options include:

- Establishing easy to use community-wide messaging systems around medical referral regions
 - Establishing a prescription refill systems
 - Enabling ED physicians to view patient data from multiple sources for a 24 hour period.
1. Convene an OMH-public health HD/HIE “point of care” committee to:
 - Identify, develop and implement HD/HIE strategies for *Maryland Plan to Eliminate Health Disparities* Plan
 - Nurture and support emerging community grass roots efforts.
 - Promote community and healthcare provider’s participation and ownership.
 - Promote public-private partnership dialogue to identify expertise and resources in Maryland
 - Recognize, encourage, partner and participate in innovative grassroots community/health advocacy
 2. Support coalition’s HIT/HIE pilots (see Prince Georges County HD/HIE Coalition and Baltimore County Coalition).
 - Encourage/support coalition’s use of clinical trials disparity discussions as the consensus builder for data sharing around clinical guidelines and best practices among public health, hospitals and providers
 - Support coalition’s efforts to engage traditional and non-traditional public-private funding sources.
 - Advocate for public policy to support needed business and economic analysis of the cost of disparities.
 3. Public Health can help community stakeholders organize and pilot services (demos) that are relatively easy to do, low risk, and low cost that community stakeholders can agree to do. Public health could participate in these activities in the following ways:
 - *Disease Registries* – partner with Maryland based Sickle Cell Association, Johns Hopkins, MedStar, MedChi, MHCC to pilot the development and access to the “first” health disparities disease registries beginning with Sickle Cell.
 - *Messaging system* – implement an inter/intra-departmental DHMH messaging system to send and receive secure messages with other providers and public health offices. There are significant cost savings to hospitals and health systems by eliminating paper, so hospitals will often support physician participation in the messaging system. Public health could potentially be supported in part or in full with funding sources identified by the HD/HIE Coalitions.
 - *Prescription refill system* – some communities are providing this for free or at low cost to encourage physician utilization to reduce medication errors. Public health and community health centers could probably participate in this with its patients, at little or no cost. Links could be made from the prescription systems to state public health for reportable conditions.
 - *ED access to patient data from multiple sources* – Several communities are establishing community-wide systems that function like a repository and are making patient summary data available to hospital ED physicians for 24 hours. This service results in better, faster care, and saves lives. It also helps identify people who go to more than one ED using various names. There are huge costs savings by the hospitals to do this, and hospitals would probably be willing to support some or all of public health’s costs to do this.